IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

January 23, 2014

Steve Young, Administrator
Yellowstone Group Home #3 Hoopes
560 West Sunnyside
Idaho Falls, ID 83402

RE: Yellowstone Group Home #3 Hoopes, Provider #13G065

Dear Mr. Young:

This is to advise you of the findings of the Medicaid/Licensure survey of Yellowstone Group Home #3 Hoopes, which was conducted on January 13, 2014.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner**:

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of

being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **February 4, 2014,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by February 4, 2014. If a request for informal dispute resolution is received after February 4, 2014, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G065	A. BUILDING _____ B. WING _____	01/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #3 HOOPES	1949 HOOPES IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey conducted from 1/6/14 - 1/13/14. The survey was conducted by: Michael Case, LSW, QIDP, Team Leader Trish O'Hara, RN Common abbreviations used in this report are: AQIDP - Assistant Qualified Intellectual Disability Professional IPP - Individual Program Plan LPN - Licensed Practical Nurse NOS - Not Otherwise Specified OCD - Obsessive Compulsive Disorder PBSP - Positive Behavior Support Plan QIDP - Qualified Intellectual Disability Professional	W 000	Please see attached of Plan of correction for all Deficiencies	
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure behavior assessments contained comprehensive information for 1 of 2 individuals (Individual #3) whose behavior assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #3's 10/17/13 IPP stated he was a 53 year old male whose diagnoses included	W 214		

RECEIVED
FEB 04 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Susan J. Weeks NHA
City Director
TITLE

(X6) DATE
2/4/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Bureau of Facility Standards

PRINTED: 01/22/2014
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G065	A. BUILDING: _____ B. WING _____	01/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #3 HOOPES	1949 HOOPES IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Initial Comments The following deficiencies were cited during the licensure survey conducted from 1/6/14 - 1/13/14. The survey was conducted by: Michael Case, LSW, QIDP, Team Leader Trish O'Hara, RN	M 000		
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by; Refer to W312.	MM197	Please see attached of Plan of correction for all Deficiencies	
MM729	16.03.11.270.01(d) Treatment Plan Objectives The individual treatment plan must state specific objectives to reach identified goals. The objectives must be: This Rule is not met as evidenced by: Refer to W289.	MM729		
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by; Refer to W214.	MM730		

RECEIVED
FEB - 4 2014
FACILITY STANDARDS

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Susan J. Wicks NHA
City Director
TITLE

(X6) DATE
2/4/14

STATE FORM 6899 GWS711 If continuation sheet 1 of 1

Hoopes Plan of Correction

Survey January 13, 2014

W214

The Hoopes Home will ensure the comprehensive functional assessment identifies the client's specific developmental and behavioral management needs.

The comprehensive functional assessments, to include the PBSP for all individuals will be reviewed and additional information included in the documents. In addition, implementation or updates will be madeito the programming based on the comprehensive functional assessment.

The positive behavior support plans are currently being reviewed and new tracking sheets implemented. In addition, staff are being trained on these changes and the implementation of this programming.

Person Responsible: QIDP/program supervisor, Behavior Specialist, and City Director.

Monitor: Quarterly a review of all comprehensive functional assessments will be completed by an in-house peer review. Program objectives will be reviewed to ensure they reflect the individual's current functioning level and need. The corporate QA will ensure that this is being done. Annually the Treatment Team will review the comprehensive functional assessment in their Interdisciplinary Team Meeting.

Objectives for programming will be determined based on the comprehensive functional assessment. Will be completed by 3/23/14.

W289. The Hoopes Home will ensure individual program plans and PBSPs state clear specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment.

All individual program plans and PBSPs will be reviewed to provide staff necessary instructions

Person Responsible: QIDP, Program Supervisor, and City Director

Monitor: Monthly QIDP and Program Supervisor will review all program objectives and individual program plans to ensure the objective necessary to meet their needs are incorporated into the individual's plans. Quarterly review of the individual's plans will be completed by the facilities in-house QA. The corporate QA will do audits to ensure the reviews are completed and documented. Annual or as need the Treatment Team will review the individual's plans. Will be completed by 3/23/14

W312

The Hoopes Home will ensure drugs used to control inappropriate behavior will be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of an eventual elimination of the behaviors for which the drugs are employed.

All medication reduction plans will be reviewed or implemented to ensure they accurately reflect and define the criteria for reduction.
Data collection documents will be implemented or reviewed to ensure accurate information based on the individuals plan is being collected.
All individual program plans will be reviewed to ensure objectives related to each diagnosis with a medication to control inappropriate behavior are implemented.
Person Responsible: Program Supervisor/ QIDP, LPN, and City Director
Monitor: Monthly the QIDP will review all individual program plans and documentation related to the number of incidents for medications used to control inappropriate behaviors. These will be cross referenced monthly with the medication reduction plans. Quarterly or as needed a review of medication reduction plans will be reviewed by the LPN. Will be completed by 3/23/14

W334
The Part time LPN assigned to do the quarterly assessments will divide the number of residents into 4 week periods of time and nursing assessments will be done on a weekly basis within quarterly month. Example: 40 residents = 10 assessments done per week this will make the work load more feasible and trackable. The full time nurse will review and complete a portion of the monthly narrative nursing notes based on assessment info. This would be a double check. All assessments will be given to the full time LPN Barb when completed. Will be completed by 3/23/14.

MM197 – Refer to W312

MM729 – Refer to W289

MM730 – Refer to W214

Jeanne Weeks
Idaho Falls City Director

2/4/14